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ABSTRACT

Assessment tools from the counseling arena can be useful in educational settings for developing effective instructional strategies and learning environments; identifying students who would benefit from referral to a mental health professional; and promoting student's growth and well-being by fostering self-awareness and identity development. In contrast to broadband instruments that provide information on a student's functioning in multiple domains, narrowband instruments provide more detailed information about a student's functioning within a particular domain or with respect to a specific problem. Combining broadband and narrowband approaches can be especially effective in offering both a general picture of a student's current level of functioning and specific information on any area in which a student appears to be having particular difficulty. This chapter provides examples of specific broadband and narrowband instruments that are commonly used in the context of counseling assessment. (Contains 52 references.) (GCP)

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Broadband and Narrowband Measures of Mental and Behavioral Health: Counseling Assessment for Educators

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Chapter 15
Broadband and Narrowband Measures of Mental and Behavioral Health

Counseling Assessment for Educators

Amy L. Conlon & Jo-Ida C. Hansen

Assessment tools from the counseling arena can be useful in educational settings for (a) developing effective instructional strategies and learning environments, (b) identifying students who would benefit from referral to a mental health professional, and (c) promoting students' growth and well-being by fostering self-awareness and identity development (Drummond, 1996). The assessment process will be most useful to students when a multifaceted approach is taken that includes naturalistic observation, interviews, valid and reliable self-report instruments, and informant reports, such as from teachers, parents, and peers (Eckert, Dunn, Codding, & Guiney, 2000). Assessment data should be placed within the context of a student's developmental phase and integrated with knowledge of the student's background (e.g., educational history, racial and ethnic identity, social history; Kronenberger & Meyer, 2001). This chapter focuses on structured assessment instruments that may play a role in this multifaceted assessment process.

Assessment instruments vary in the scope of behavioral and emotional functioning they cover. *Broadband* instruments provide information on a wide range of psychological, behavioral, and social domains that may have relevance to multiple problems or disorders. This type of broad-based knowledge can be useful regardless of the specific issue or problem facing a student (Kronenberger & Meyer, 2001). Personality inventories, symptom checklists, self-concept scales, and behavior rating scales are examples of broadband instruments. These tools can help identify students who would benefit from special accommodations or who require referral to an outside mental health professional. Many of these instruments also highlight areas of competency, which can facilitate the development of educational interventions that build upon students' assets and strengths.

In contrast to broadband instruments that provide information

on a student's functioning in multiple domains, *narrowband* instruments provide more detailed information about a student's functioning within a particular domain (e.g., social skills) or with respect to a specific problem (e.g., depression; Eckert et al., 2000). Combining broadband and narrowband approaches can be especially effective in offering both a general picture of a student's current level of functioning and specific information on any area in which a student appears to be having particular difficulty. Eckert et al. (2000) suggested that this type of approach "results in a comprehensive assessment of potential behavior problems that concludes with a detailed examination of specific emotional or behavioral functioning" (p. 151). The remainder of this chapter provides examples of specific broadband and narrowband instruments that are commonly used in the context of counseling assessment.

Self-Report

Self-report instruments require test takers to respond to items that reflect on their behaviors, feelings, and attitudes. These types of tests can provide useful information on students' internal processes that might not be evident to an outside observer. Some students might not have the necessary self-awareness or insight to describe their inner experiences accurately, however, thus limiting the validity of the results. Preadolescent students in particular might respond in socially desirable ways in their efforts to provide the "correct" answer. Lack of motivation as well as reading and comprehension difficulty may further limit the accuracy of self-report data from students (Kronenberger & Meyer, 2001).

The Personality Inventory for Youth (PIY; Lachar & Gruber, 1995) is a 270-item self-report inventory designed for students in grades 4 through 12. This broadband personality instrument provides information on a student's level of functioning, relative to a norm group, in nine dimensions: cognitive impairment, impulsivity and distractibility, delinquency, family dysfunction, reality distortion, somatic concerns, psychological discomfort, social withdrawal, and social skills deficits. Its companion instrument, the Personality Inventory for Children (PIC; Wirt, Lachar, Klinedinst, & Seat, 1977), is appropriate for children ages 3 to 16 and is completed by the parent. A strength of both the PIY and PIC is their focus on typical developmental problems as well as disturbed behaviors. Both instruments are also well researched and have large norm groups upon which scores are based (Wodrich, 1997).

The Millon Adolescent Personality Inventory (MAPI; Millon & Davis, 1993), another self-report personality instrument, was designed to assess domains relevant to normal developmental processes. The inventory requires at least a sixth-grade reading level and provides scores on 24 scales representing opposing personality styles. An overall index of adjustment is also provided. The scales cover three broad domains of functioning motivating goals, cognitive style, and interpersonal behavior (Hood ... Johnson, 1997).

The Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994) is a self-report instrument that focuses on specific symptoms rather than on personality styles. The instrument is appropriate for students older than 13, and it requires respondents to rate 90 items addressing the severity with which they have experienced a range of mental health problems. Nine areas of psychological symptoms are covered: somatization, obsessive-compulsive behaviors, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The SCL-90-R also provides a global severity index of overall symptom severity (Kronenberger & Meyer, 2001).

Several broad measures of self-concept and self-esteem are useful for assessing students' self-views. Self-esteem is an important component of emotional functioning that relates to both clinically significant disorders (e.g., depression, social anxiety, eating disorders) and overall student adjustment. The Piers-Harris Children's Self-Concept Scale (PHCSCS; Piers, 1984) is an 80-item measure that assesses self-concept in the domains of behavior, intellectual/school status, physical appearance, anxiety, popularity, and happiness/satisfaction. A total scale score that reflects global self-concept is also provided. Concerns have been raised about the outdated norm sample of the PHCSCS, however, suggesting the need for cautious interpretation of these scores (Eckert et al., 2000; Kalfus, 1995).

The Multidimensional Self-Concept Scale (MSCS; Bracken, 1992) has an adequate norm sample and might be viewed as easier to interpret than the PHCSCS. The six subscales of the MSCS (Affect, Academic, Competence, Family, Physical, Social) can be administered and interpreted separately. Like the PHCSCS, the MSCS provides a global index of self-concept (Eckert et al., 2000). There is a special version of the Coopersmith Self-Esteem Inventories (SEI; Coopersmith, 1981) designed specifically for use in schools. The School Form is appropriate for students ages 8 to 15 and yields information on overall self-esteem as well as self-esteem with respect to peers, parents, school, and personal interests. The Behavior Academic Self-Esteem (BASE)

rating scales (Coopersmith & Gilbert, 1982) is used in conjunction with the Coopersmith self-report inventories. Teachers complete the BASE, which was designed to serve as a check on student self-reports (Hood & Johnson, 1997).

Multiperspective Rating Systems

A number of test developers have designed assessment systems intended to facilitate information gathering from multiple sources. These systems typically include a combination of checklists and rating scales that are completed by teachers and parents as well as self-report inventories to which students respond. Obtaining information on a student's functioning from multiple perspectives offers a comprehensive view of the student's current adjustment level; however, the use of these assessment systems can be complicated, and integrating the information often requires clinical skill (Wodrich, 1997).

An example of a multiperspective rating system is Conners' Rating Scales-Revised (Conners, 1997), which collects information from parents (Conners' Parent Rating Scale-Revised, CPRS-R), teachers (Conners' Teacher Rating Scale-Revised, CTRS-R), and students (Conners-Wells' Adolescent Self-Report Scale, CASS). The CPRS-R and the CTRS-R ask parents and teachers to rate the severity of behavior problems in children and adolescents ages 3 to 17. Items assess a variety of problem domains, including anxiety, shyness, perfectionism, and social difficulties. The scales also provide information on the extent to which a student exhibits the symptoms of attention deficit/hyperactivity disorder, which can be useful for screening students for attention and concentration problems. For students ages 12 to 17, the CASS can augment information obtained from parents and teachers by providing students' perspectives on family problems, emotional difficulties, conduct problems, cognitive problems, anger control problems, and hyperactivity (Kronenberger & Meyer, 2001).

Another comprehensive assessment system that gathers data from multiple perspectives is the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992). The Parent Rating Scale (BASC-PRS) comes in forms for three age groups—preschool (ages 4 and 5), child (ages 6 to 11), and adolescent (ages 12 to 18). Based on the previous six months, parents rate the extent to which their child exhibited behaviors relevant to internalizing problems, externalizing problems, school difficulties, and adaptive skills. An overall index of behavioral symptoms is also provided. The Teacher Rating Scale

(BASC-TRS) elicits the same information as the parent scales with the addition of two scales that assess learning problems and study skills.

A third component of the BASC, the Self-Report of Personality (SRP), can be used with children and adolescents ages 8 to 18. This self-report inventory yields information on how students view their own level of functioning in terms of clinical maladjustment, school maladjustment, personal maladjustment, and emotional symptoms (Kronenberger & Meyer, 2001). The scope of clinical disorders assessed by the SRP is fairly limited, especially in the domain of externalized problems such as aggression; however, school-based practitioners are likely to find the school maladjustment items especially helpful (Eckert et al., 2000).

In addition to the three scales, the BASC includes structured approaches for behavioral observation (Structured Observation System, SOS) and developmental history collection (Structured Developmental History), which have enjoyed widespread use in school settings because of their focus on school-relevant problems and competencies and their developmentally appropriate items (Kronenberger & Meyer, 2001). The SOS is especially useful in making decisions about enrolling students in special programs because it offers a systematic approach for quantifying classroom behaviors (Wodrich, 1997). Although the BASC has been described as "impressive" in terms of both the construction of the scales and the research base supporting their validity, the extensive length of the rating scales might preclude its use for routine screening (Merrell, 2000).

Projective Tests

Projective tests are another class of broadband personality measures that have enjoyed popularity among clinicians working with children and adolescents. Examples of projective tests include the Rorschach Technique (Klopfer, 1962); storytelling approaches, such as the Thematic Apperception Test (Stein, 1955) and Roberts Apperception Test for Children (Roberts, 1994); and various drawing techniques, for example, Kinetic Family Drawings (Burns & Kaufman, 1972). Respondents are assumed to project their feelings, thoughts, needs, conflicts, and attitudes onto ambiguous stimuli, and these responses are believed to be representative of daily behavior and overall adjustment.

Compared with pencil-and-paper objective tests, projective approaches have been described as less threatening and more engaging

for children. The great amount of training and clinical skill required to administer and interpret projective tests precludes their use in many school settings, however (Wodrich, 1997). Additional limitations of projective approaches are the often subjective manner in which the tests are interpreted and the fact that responses are affected by transient state factors such as hunger, mood, and frustration (Kronenberger & Meyer, 2001).

Assessing Relationship and Social Skills

Children and adolescents face many important developmental tasks in their relationships and other social interactions. As children develop, their peer groups typically grow as they increasingly seek from friends the support they previously obtained from family members. Moreover, changes in peer groups due to a family move or changes in familial relationships due to divorce are common experiences among children and adolescents. There is evidence that the relationships and social interactions experienced in childhood and adolescence have implications for later psychological adjustment. For example, young people who experience social isolation are at higher risk for dropping out of school, engaging in criminal behavior, and experiencing a wide range of clinically significant emotional and behavioral problems. Deficits in social skills similarly appear to be associated with conduct problems, depression, and anxiety (Hansen, Giacoletti, & Nangle, 1995).

A variety of assessment tools are available for formally evaluating students' social skills. Information garnered from these instruments can be useful in identifying at-risk children and developing interventions to bolster social competence in students. The Social Skills Rating System-Student Form (SSRS-S; Gersham & Elliott, 1990) asks students to evaluate themselves in five domains of social functioning: assertion, cooperation, empathy, interfering behaviors, and self-control. Students are also asked about the frequency and importance of various social behaviors, which can help identify target behaviors for interventions (Eckert et al., 2000). Parent and teacher forms of the SSRS also are available, facilitating the collection of information from multiple perspectives (Merrell, 2000). Teacher and student perspectives are captured in the Matson Evaluation of Social Skills with Youngsters (MESSY; Matson, Rotatori, & Helsel, 1983). Teachers respond to items that rate students' inappropriate assertiveness, impulsivity, and appropriate social skills. The self-report form assesses students' perspectives on their appropriate social skills, inappropriate

assertiveness, overconfidence, impulsivity, jealousy, and withdrawal behaviors (Kalfus, 1995).

Teacher ratings of students' social competence can be gathered using the Walker-McConnell Scales of Social Competence and School Adjustment (Walker & McConnell, 1995a, 1995b) and the School Social Behavior Scales (SSBS; Merrell, 1993). Both instruments can be used with students from kindergarten through 12th grade and are relatively brief and easy to administer and score. Because they both focus solely on social competence, additional assessment tools should be used if other problem behaviors within the social domain are suspected (Merrell, 2000).

Assessing Anxiety

Many of the anxieties and fears that emerge in childhood and adolescence are part of normal developmental processes that dissipate with age and have no long-term consequences in adulthood. A challenge in assessing anxiety in young people, then, is determining whether symptoms are developmentally appropriate or warrant additional evaluation and formal intervention (Kazdin, 1994). Anxiety problems most frequently observed in children and adolescents include social anxiety, generalized anxiety, separation anxiety, specific phobias, panic, school refusal behavior, and test anxiety. Obsessive-compulsive behavior and post-traumatic stress disorder also may occur in children and adolescents. Symptoms of anxiety manifest as subjective cognitions (e.g., persistent worries), overt behaviors (e.g., avoidance/withdrawal), and physiological reactivity (e.g., increased heart rate); thus, the most effective assessment strategies examine symptoms across these three domains (Kearney & Silverman, 1995).

Broadband instruments that provide information relevant to anxiety symptoms include the BASC, PIY, Child Behavior Checklist (CBCL; Achenbach, 1991), and Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A; Butcher et al.,1992; Kronenberger & Meyer, 2001).

The Multidimensional Anxiety Scale for Children (MASC; March, 1997) is an example of a self-report inventory that covers multiple domains of symptoms. The 39 items assess physical symptoms, harm avoidance behavior, social anxiety, and separation fears/panic (Kronenberger & Meyer, 2001). A separate form, the MASC-10, assesses symptoms of generalized anxiety. The MASC is useful for providing information on a wide range of anxiety symptoms and can

help differentiate between generalized and specific anxiety disorders, which might prove useful in identifying students who need outside referrals and for targeting behaviors for intervention (Eckert et al., 2000).

The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978) also provides information on anxiety across several domains, including worry/oversensitivity symptoms, physiological symptoms, and concentration-related symptoms. Although the instrument has adequate research supporting its reliability and validity, the overlap of some items with symptoms of depression has been cited as a limitation of the RCMAS (Kronenberger & Meyer, 2001).

The State-Trait Anxiety Inventory for Children (STAIC; Spielberger, Edwards, Lushene, Montouri, & Platzek, 1973) differentiates between transitory (state) anxiety and more enduring generalized (trait) anxiety. The two 20-item subscales have been shown to discriminate effectively between children suffering from anxiety disorders and children diagnosed with clinically significant depression; however, the scales do not differentiate among various types of anxiety disorders. Utility of the STAIC with very young children might be limited because they may not be able accurately to distinguish transitory from stable anxiety (Kronenberger & Meyer, 2001).

Assessing Depression

Children and adolescents who are suffering from clinically significant depression are characterized by pervasive sadness, limited interest in activities, diminished energy, and feelings of worthlessness. Changes in appetite, weight, and sleep patterns are also common (Kazdin, 1994). Depression greatly affects the social and emotional functioning of children and adolescents and has been shown to increase risk for adult psychopathology (Reynolds, 1995). Children whose depression goes untreated are more likely to experience future adjustment problems, such as dropping out of school, unemployment, substance use, and criminal behavior. In addition, students experiencing clinically significant levels of depression are at higher risk for suicide, a leading cause of death among adolescents.

Assessment of depression can be complicated because it is not always easy to distinguish between clinically significant depressive symptoms and the volatile and labile moods and emotions that are normative characteristics of the adolescent developmental stage. Thus, an understanding of developmental aspects of children's and

adolescents' moods is necessary to interpret measures of depression accurately (Caldwell, 1999).

Depression has been described as a prototypical internalizing disorder because the core symptoms are known only to the person experiencing them and thus are not observable by others. Therefore, self-report measures of depression are popular, and they have the added benefits of being easy to administer and appropriate for group administration, which makes them ideal for school settings. A diagnosis of depression cannot be made from these self-report inventories alone, but they provide an index of symptom severity and are good tools for identifying students who would benefit from further evaluation (Reynolds, 1995).

The drawbacks of self-report measures include the potential for students to misinterpret their symptoms or to have difficulty discerning whether symptoms are due to depression or other life events. Furthermore, because most children and adolescents have had limited life experiences, they may lack the context necessary to evaluate subjectively the severity of their symptoms. There is evidence that adolescents' moods are more heavily influenced by environmental factors than adults' moods are, which may further limit the accuracy of self-reports (Caldwell, 1999). Despite these limitations, self-report measures are viewed by some clinicians as more accurate than measures based on the observations of parents, especially in light of adolescents' reluctance to disclose feelings to their parents. Research comparing parent and child reports of depressive symptoms has typically found low levels of agreement (Reynolds, 1995).

The Children's Depression Inventory (CDI; Kovacs, 1992) is one of the most widely used measures of depression in young people (Eckert et al., 2000; Reynolds, 1995). The inventory, which is appropriate for ages 6 through 17, includes 27 items that assess cognitive, affective, behavioral, and social aspects of depression. The CDI is considered a downward extension of the Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996), which is a popular self-report measure used with adolescents and adults. The materials accompanying the CDI provide cutoff scores designed to help practitioners identify children at particular risk for clinical depression. The norm sample upon which these cutoff scores are based has been criticized, however, so these scores should be used conservatively. Evidence that the CDI does not effectively discriminate between children suffering from depression and those experiencing other clinically significant problems (most notably anxiety), suggests that it might be best viewed as a general

measure of overall distress as opposed to a specific measure of depressive symptomatology (Eckert et al., 2000; Kronenberger & Meyer, 2001).

Two instruments that may be especially useful for school-based screening of depression are the Reynolds Child Depression Scale (RCDS), for grades 3 to 6 (Reynolds, 1989) and the Reynolds Adolescent Depression Scale (RADS), for grades 7 to 12 (Reynolds, 1987). Both instruments are based on large norm samples, and a large body of research supports their validity and reliability (Kronenberger & Meyer, 2001; Reynolds, 1995). The content items make the RCDS and the RADS appropriate for diagnostic purposes, and a global severity index provides information on the intensity of the depressive symptoms (Eckert et al., 2000).

In addition to the narrowband measures described above, a number of broadband instruments reviewed in the previous section also provide information that can assist in identifying depressed students. For instance, the MMPI-A, CBCL, and BASC all include subscales reflecting depressive symptomatology (Reynolds, 1995). Structured interviews that assess a range of mental health issues, such as the Diagnostic Interview for Children and Adolescents (DICS; Reich, Welner, Herjanic, & MHS staff, 1997) and the Child Assessment Schedule (CAS; Hodges, 1987), may also be useful because depression in young people often coexists with other behavioral and emotional problems (Caldwell, 1999).

Assessing Conduct Problems

Conduct problems, or conduct disorders (CDs), are characterized by a persistent pattern of antisocial behavior that is significant enough to impair daily functioning across numerous life domains (Borduin, Henggeler, & Manley, 1995). The assessment of conduct problems should include collecting information from multiple perspectives, using multiple methods, and examining behavior across a wide range of settings (e.g., in school, at home, with peers). Moreover, because children and adolescents are likely to misbehave or exhibit disruptive behaviors as they negotiate the developmental tasks of growing up, it is important to distinguish a persistent pattern of disruptive behavior that occurs in multiple situations before attempting to diagnose a CD. There is not a single assessment tool that is sufficient to establish the existence of CDs; however, several self-report and other instruments are available that could play a role in the assessment process.

The Eyberg Child Behavior Inventory (ECBI; Eyberg & Ross, 1978) is a rating scale that parents complete by indicating whether their child exhibits any of 36 behaviors commonly reported by parents of children with CDs. Parents rate each behavior in terms of whether the problem exists and the frequency of the problem. Appropriate for children and adolescents ages 2 to 17, the ECBI is considered unidimensional and suggests that the existence of 11 or more of the problems indicates clinically significant conduct problems (Kalfus, 1995; Kronenberger & Meyer, 2001). A simple and quick means of identifying behavior problems is provided by the original Ontario Child Health Study (OCHS) scales, for ages 12 to 16 (Boyle et al., 1993). Separate parent report, teacher report, and self-report forms are used, each of which asks about 34 behavior problems associated with CDs, hyperactivity, and emotional disturbances. The OCHS scales can be administered quickly in a school setting and are a simple screening method for conduct problems (Kronenberger & Meyer, 2001). The New York Teacher Rating Scale (NYTRS; Miller et al., 1995) is another screening instrument that educators and school-based practitioners may find useful for identifying students with clinically significant conduct problems. This 36-item teacher report assesses oppositional behaviors, peer rejection, aggression, and rule breaking in students grades 1 through 10 (Kronenberger & Meyer, 2001).

Social attribution and problem-solving measures can also be helpful in identifying children with conduct problems, because low levels of social problem-solving ability have been shown to relate to conduct disorders among children. These types of assessment tools typically evaluate how children approach solving problems related to social situations. For example, the Means End Problem Solving Procedure (MEPS; Platt & Spivak, 1975) provides children with the beginning and an end of a story and asks them to provide the middle portion of the story. The task requires children to specify in behavioral terms how the goals attained at the end of the story were reached. Responses are coded based on relevance of behavior to goal achievement, awareness of obstacles, and appropriateness of sequencing and passage of time. The responses of children diagnosed with a CD have been shown to contain fewer relevant means and fewer obstacles in pursuit of social goals (Kronenberger & Meyer, 2001).

Anger and aggression inventories are additional tools for assessing conduct problems in children and adolescents because conduct problems are sometimes secondary to anger control problems. Children diagnosed with conduct disorder typically report more anger and less control over

their anger, and tend to describe more aggressive reactions to anger-provoking situations. Examples of anger and aggression inventories include the Buss-Durkee Hostility Inventory (BDHI), for adolescents and adults (Buss & Durkee, 1957); the Novaco Anger Inventory (NAI), for adolescents and adults (Novaco, 1975); the Children's Anger Response Checklist (CARC), for children and adolescents (Feindler, Adler, Brooks, & Bhumitra, 1993); and the State-Trait Anger Expression Inventory (STAXI), for adolescents (Spielberger, 1988).

Conclusion

Childhood and adolescence are marked by exciting developmental milestones as well as an array of challenges. Educators and professionals working in educational institutions are well positioned to promote students' growth through these important developmental stages and to help them overcome challenges that may be creating difficulties in school, at home, and with peers. Assessment tools from the counseling arena can play an important role in these processes. The most effective assessment strategy incorporates information from a variety of sources (e.g., child, parent, teacher) and utilizes a variety of approaches (e.g., interview, naturalistic observation, self-reports, teacher and parent reports). Furthermore, to obtain a comprehensive picture of a student's current functioning, it is desirable to combine broadband assessment instruments that cover an array of domains with problem-specific narrowband instruments. Broadband personality inventories can alert educators to particular problem areas and highlight areas of strength and competency. Narrowband instruments assessing depression, anxiety, social skills, self-esteem, self-concept, and conduct problems have particular relevance to educational settings because they highlight problems that might be interfering with a student's performance in school, in classroom behavior, and in peer relationships. A growing recognition of the impact of these problems on young people has led to the development of a wide array of valid and reliable assessment instruments that can play an important role in helping students succeed.

References

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist/4–18 and 1991 Profile.* Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M. (1992). *Manual for the Child Behavior Checklist/2–3 and 1992 profile.* Burlington, VT: University of Vermont, Department of Psychiatry.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *BDI-II, Beck Depression Inventory: Manual.* San Antonio, TX: Psychological Corporation.

Borduin, C. M., Henggeler, S. W., & Manley, C. M. (1995). Conduct and oppositional disorders. In V. B. Van Hasselt & M. Hersen (Eds.), *Handbook of adolescent psychopathology: A guide to diagnosis and treatment* (pp. 349–382). New York: Lexington Books.

Boyle, M. H., Offord, D. R., Racine, Y., Sanfors, M., Szatmari, P., & Fleming, J. E. (1993). Evaluation of the original Ontario Child Health Study scales. *Canadian Journal of Psychiatry, 38,* 397–405.

Bracken, B. A. (1992). *Multidimensional Self-Concept Scale: Examiner's manual.* Austin, TX: PRO-ED.

Burns, R. C., & Kaufman, S. H. (1972). *Actions, styles and symbols in Kinetic Family Drawings (K-F-D): An interpretive manual.* New York: Brunner/Mazel.

Buss, A. H., & Durkee, A. (1957). An inventory for assessing different kinds of hostility. *Journal of Consulting Psychology, 21,* 343–348.

Butcher, J. N., Williams, C. L., Graham, J. R., Tellegen, A., Ben-Porath, J. S., & Kaemmer, B. (1992). *MMPI-A: Manual for administration, scoring, and interpretation.* Minneapolis, MN: University of Minnesota.

Caldwell, C. (1999). Counseling depressed boys. In A. M. Horne & M. S. Kiselica (Eds.), *Handbook of counseling boys and adolescent males* (pp. 279–292). Thousand Oaks, CA: Sage Publications.

Conners, C. K. (1997). *Conners' Rating Scales-Revised technical manual.* North Tonawanda, NY: Multi-Health Systems.

Coopersmith, S. (1981). *Self-Esteem Inventories (SEI).* Palo Alto, CA: Consulting Psychologists Press.

Coopersmith, S., & Gilbert, R. (1982). *Professional manual: Behavior Academic Self-Esteem (BASE), a rating scale.* Palo Alto, CA: Consulting Psychologists Press.

Derogatis, L. R. (1994). *SCL-90-R administration, scoring, and procedures manual—third edition.* Minneapolis, MN: National Computer Systems.

Drummond, R. J. (1996). *Appraisal procedures for counselors and helping professionals.* (3rd ed.). Englewood Cliffs, NJ: Merrill.

Eckert, T. L., Dunn, E. K., Codding, R. S., & Guiney, K. M. (2000). Self-report: Rating scale measures. In E. S. Shapiro & T. R. Kratochwill (Eds.), *Conducting school-based assessments of child and adolescent behavior* (pp. 150–169). New York: Guilford Press.

Eyberg, S. M., & Ross, A. W. (1978). Assessment of child behavior problems: The validation of a new inventory. *Journal of Clinical Child Psychology, 7,* 113–116.

Feindler, E. L., Adler, N., Brooks, D., & Bhumitra, E. (1993). The development and validation of the Children's Anger Response Checklist (CARC). In L. Vandecreek (Ed.), *Innovations in clinical practice* (Vol. 12, pp. 337–362). Sarasota, FL: Professional Resources Press.

Gersham, F. M., & Elliott, S. N. (1990). *The Social Skills Rating System.* Circle Pines, MN: American Guidance Service.

Hansen, D. J., Giacoletti, A. M., & Nangle, D. W. (1995). Social interactions and adjustment. In V. B. Van Hasselt & M. Hersen (Eds.), *Handbook of adolescent psychopathology: A guide to diagnosis and treatment* (pp. 102–129). New York: Lexington Books.

Hodges, K. K. (1987). Assessing children with a clinical interview: The Child Assessment Schedule. In R. J. Prinz (Ed.). *Advances in behavioral assessment of children and families.* Greenwich, CT: JAI Press.

Hood, A. B., & Johnson, R. W. (1997). *Assessment in counseling: A guide to the use of psychological assessment procedures* (2nd ed.). Alexandria, VA: American Counseling Association.

Kalfus, G. R. (1995). Behavioral assessment in adolescents. In V. B. Van Hasselt & M. Hersen (Eds.), *Handbook of adolescent psychopathology: A guide to diagnosis and treatment* (pp. 243–264). New York: Lexington Books.

Kazdin, A. E. (1994). Psychotherapy for children and adolescents. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 543–594). New York: John Wiley & Sons.

Kearney, C. A., & Silverman, W. K. (1995). Anxiety disorders. In V. B. Van Hasselt & M. Hersen (Eds.), *Handbook of adolescent psychopathology: A guide to diagnosis and treatment* (pp. 435–464). New York: Lexington Books.

Klopfer, Bruno. (1962). *The Rorschach Technique: An introductory manual.* New York: Harcourt, Brace and World.

Kovacs, M. (1992). *Children's Depression Inventory (CDI) manual.* North Tonawanda, NY: Multi-Health Systems.

Kronenberger, W. G., & Meyer, R. G. (2001). *The child clinician's handbook* (2nd ed.). Boston: Allyn and Bacon.

Lachar, D., & Gruber, C. P. (1995). *Personality Inventory for Youth (PIY) manual.* Los Angeles: Western Psychological Services.

March, J. (1997). *Multidimensional Anxiety Scale for Children technical manual.* North Tonawanda, NY: Multi-Health Systems.

Matson, J. L., Rotatori, A. F., & Helsel, W. J. (1983). Development of a rating scale to measure social skills in children: The Matson Evaluation of Social Skills with Youngsters (MESSY). *Behavior Research and Therapy, 21,* 335–340.

Merrell, K. W. (1993). *School Social Behavior Scales.* Austin, TX: PRO-ED.

Merrell, K. W. (2000). Informant-report: Rating scale measures. In E. S. Shapiro & T. R. Kratochwill (Eds.), *Conducting school-based assessments of child and adolescent behavior* (pp. 203–234). New York: Guilford Press.

Miller, L. S., Klein, R. G., Piacentini, J., Abikoff, H., Shah, M. R., Samilor, A., & Guardino, M. (1995). The New York Teacher Rating Scale for disruptive and antisocial behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 34,* 359–370.

Millon, T., & Davis, R. D. (1993). The Millon Adolescent Personality Inventory and the Millon Adolescent Clinical Inventory. *Journal of Counseling and Development, 71,* 570–574.

Novaco, R. (1975). *Anger control: The development and evaluation of an experimental treatment.* Lexington, MA: Lexington Books.

Piers, E. V. (1984). *Piers-Harris Children's Self-Concept Scale Revised manual 1984.* Los Angeles: Western Psychological Services.

Platt, N. J., & Spivak, G. (1975). *Manual for the Means End Problem Solving Procedure (MEPS): A measure of interpersonal cognitive problem solving skill.* Unpublished manuscript.

Reich, W., Welner, Z., Herjanic, B., & MHS Staff. (1997). *Diagnostic Interview for Children and Adolescen's computer program (DICS-IV).* North Tonawanda, NY: Multi-Health Systems.

Reynolds, C. R., & Kamphaus, R. W. (1992).*Behavior Assessment System for Children manual.* Circle Pines, MN: American Guidance Service.

Reynolds, C. R., & Richmond, B. O. (1978). What I think and feel: A revised measure of children's manifest anxiety. *Journal of Abnormal Child Psychology, 6,* 271–280.

Reynolds, W. M. (1987). *Assessment of depression in adolescents: Manual for the Reynolds Adolescent Depression Scale (RADS).* Odessa, FL: Psychology Assessment Resources.

Reynolds, W. M. (1989). *Reynolds Child Depression Scale: Professional manual.* Odessa, FL: Psychology Assessment Resources.

Reynolds, W. M. (1995). Depression. In V. B. Van Hasselt & M. Hersen (Eds.), *Handbook of adolescent psychopathology: A guide to diagnosis and treatment* (pp. 297–348). New York: Lexington Books.

Roberts, G. E. (1994). *Interpretive handbook for the Roberts Apperception Test for Children.* Los Angeles: Western Psychological Services.

Spielberger, C. D. (1988). *Manual for the State-Trait Anger Expression Inventory (STAXI).* Odessa, FL: Psychological Assessment Resources.

Spielberger, C. D., Edwards, C. D., Lushene, R. E., Montouri, J., & Platzek, D. (1973). *Preliminary manual for the State-Trait Anxiety Inventory for Children.* Palo Alto, CA: Consulting Psychologists Press.

Stein, M. I. (1955). *The Thematic Apperception Test: An introductory manual for its clinical use with adults.* Cambridge: MA: Addison-Wesley.

Walker, H. M., & McConnell, S. R. (1995a). *Walker-McConnell Scale of Social Competence and School Adjustment: Adolescent version.* San Diego, CA: Singular Publishing Group.

Walker, H. M., & McConnell, S. R. (1995b). *Walker-McConnell Scale of Social Competence and School Adjustment: Elementary version.* San Diego, CA: Singular Publishing Group.

Wirt, R. D., Lachar, D., Klinedinst, J. K., & Seat, P. D. (1977). *Multidimensional description of personality: A manual for the Personality Inventory for Children*. Los Angeles: Western Psychological Services.

Wodrich, D. L. (1997). *Children's psychological testing* (3rd ed.). Baltimore, MD: Paul H. Brookes.

20

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